Legal Disclaimer: The views and opinions contained in the educational offerings described in this publication do not necessarily reflect those of the Division of Mental Health and Substance Abuse or the Department of Health and Social Services, and should not be construed as such.

LEARNING CONTRACT

PLEASE PRINT

PLEASE COMPLETE ALL REQUESTED INFORMATION TO ENSURE PROCESSING AND REGISTRATION

WORKSHOPS REQUESTED

LAST NAME	FIRST NAME	1) WORKSHOP NUMBER	DATE
BUSINESS / AGENCY ADDRESS			
DOSINESS / AGENCT ADDRESS		LOCATION	
CITY STATE	ZIP CODE		
())	$ooknote{WORKSHOP\ TITLE}$ How do you meet the prerequi	site? (if applicable)
HOME PHONE B	USINESS PHONE		
		2)	
E-MAIL ADDRESS		2) WORKSHOP NUMBER	DATE
		LOCATION	
DISABLED (CHECK ONE) GENDER (CHECK ONE) □YES □NO □M □F		LOCATION	
		WORKSHOP TITLE How do you meet the prerequi	usite? (if applicable)
HIGHEST DEGREE COMPLETED	(CIRCLE ONE)		
HS GED AA LPN RN BA	/S MA/S MSW PH/MD		
I WILL BE APPLYING FOR CEU'S WITH:		3)—WORKSHOP NUMBER	DATE
(SEE THE CERTIFICATION SECTION OF LOG FOR DETAILS)	THE DSAMH TRAINING CATA-		
□CEAP □DBN □DCB □DPA □NAADAC□NCC □NCGC		LOCATION	
		WORKSHOP TITLE How do you meet the prerequi-	site? (if applicable)
AGENCY Agency Code: Agen	nov Namos	I understand that I should receive a confirma	ation of
Agency Code: Agency Name: (see back of this form for list of agency codes)		admission to a workshop before I attend. IF I AM NOT	
	,	ABLE to attend a workshop, I will notify the	
POSITION: PLEASE CHEC	CK THE ONE THAT	Office at least 4 days in advance. I understa	
BEST DESCRIBES YOU:		all NO-SHOWS (someone who was admitted	
☐ Administrator/Manager	☐ Physician	workshop, did not attend, and did not alert the Office) will be reported to my Program Direction	•
☐ Aide/Outreach	☐ Prevention Worker	monthly basis.	otor on a
☐ Case Manager/Counselor/Therapist	☐ Psychologist		
☐ Chaplain/Ministry	☐ Social Worker	A DDI ICANIT CICNIATUDE	DATE
□ Consultant	☐ Student	APPLICANT SIGNATURE	DAIE
☐ Consumer	☐ Supervisor (clinical)	SUPERVISOR SIGNATURE (REQUIRED)	DATE
☐ Educator/Teacher/Instructor	☐ Support Staff		
☐ Employee Assistant Personnel	☐ Volunteer	SUPERVISOR FULL NAME (PRINT ONLY)	
□ Nurse	☐ Other		
		SUPERVISOR E-MAIL	
ETHNICITY: (CIRCLE ONE)		ALL REQUESTED SIGNATURES ARE REQUIRED FOR	
	frican American Caucasian	PROCESSING AND REGISTRATION	
Hispanic Native American Pacific	Islander Other		

Mail or FAX the completed Learning Contract to:

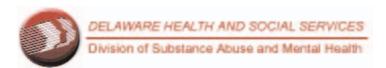
DSAMH Training Office

Springer Building, 1901 N. Dupont Highway

New Castle, DE 19720 Fax: (302) 255-4450

HAVE QUESTIONS?

For further information, call (302) 255-9480 or e-mail us at DSAMH.training@state.de.us



- AA. Aquila of Delaware, Inc.
- AB. Brandywine Community Resource Council, Inc.
- AC. Brandywine Counseling
- AD. Carelink Community Support Services
- AE. Central Delaware Committee on Drug & Alcohol Abuse
- AF. Christiana Care Health Services
- AG. Community Mental Health Centers
- AH. Connections
- AI. Delaware Council on Gambling Problems
- AJ. Delaware Psychiatric Center
- AK. Delmarva Rural Ministries
- AL. Dover Behavioral Health
- AM. DSAMH Central Office
- AN. Fellowship Health Resources
- AO. Gateway Foundation
- AP. Gaudenzia, Inc.
- AQ. Horizon Healthcare of Delaware
- AR. Horizon House of Delaware
- AS. Hudson Health Services
- AT. K/S Detox Center
- AU. Kent County Counseling
- AV. La Red Health Center
- AW. Latin American Community Center
- AX. Limen House
- AY. Mental Health Association
- AZ. MLK Center
- BA. National Alliance for the Mentally III of Delaware (NAMI-DE)
- BB. NET (Delaware), Inc.
- BC. OPEI (Office of Prevention and Early Intervention)
- BD. Psychotherapeutic Services, Inc.
- BE. Resources for Human Development
- BF. Serenity Place
- BG. SODAT
- BH. Sussex County Counseling
- BI. Treatment Access Centers
- BJ. Thresholds, Inc.
- BK. Universal Health Services
- BL. Westside Health
- BM. Whatcoat Social Services Agency, Inc.
- BN. Other